ANNUAL REPORT

Placement Coordination Service

Hamilton-Wentworth Ontario

PCS

1984-85

ANNUAL REPORT
OF THE
PLACEMENT COORDINATION SERVICE
(FORMERLY ASSESSMENT & PLACEMENT SERVICE)
OF
HAMILTON-WENTWORTH, ONTARIO

ADVISORY COMMITTEE:

Mr. H. R. Grant - Chairman

Dr. J. R. D. Bayne	Dr. R. Kirby
Dr. G. Flight	Mrs. D. H. McKibbon
Dr. J. D. Galloway	Ms. J. Orr
Mr. N. Janjic	Mr. C. Salciccoli
Mr. P. Johnson	Mrs. J. Ralph
Mrs. M. Kirstine	Mrs. N. Hassel

Ex-officio:

Chairman, VON Board, Hamilton-Dundas:	Miss J. Eagle
District Director, VON Hamilton-Dundas:	Mrs. D. Roe

MEDICAL ADVISOR: Dr. J. R. D. Bayne

STAFF:

Administrator	Miss J. Caygill
Assessment Counsellors	Mrs. B. Carson
	Mrs. J. Cooper
	Ms. G. G. Elliott
Secretaries	Mrs. J. Mason
	Ms. V. Watson

CONTENTS

HISTORICAL BACKGROUND

The A.P.S. was established by the Hamilton District Health Council in 1971 on the advice of the then newly formed Extended Care Committee. The project was funded in April of that year by the Ontario Ministry of Health and commenced operation in September 1971.

One of the concerns of the Health Council has been the promotion of optimal utilization of the services for the disabled and chronically ill. The Extended Care Committee was formed to study the needs of this group and the services available. The result of their discussions was the recommendation that a coordinating body be formed to obtain the medical, social and nursing evaluations of the disabled and chronically ill and make recommendations of the appropriate programs or levels of care for the development of the individual's assets and potential.

The Health Council appointed a medical consultant and two members of the health professions to provide the coordinating evaluation function; a part-time administrator and secretarial staff; and a data analyst to maintain statistics for the evaluation of the service's efficacy and the provision of an information base for future planning in the health needs of the disabled.

ASSESSMENT FORM

Prior to commencement of operation an Assessment tool was developed to provide the necessary information for appropriate recommendation. Broadly, this information falls into three categories:

(a) demographic (age, sex, marital status, next-of-kin, education, employment and cultural background, present location and level of income)

(b) medical (diagnosis, prognosis, treatment, level of cognitive function, emotional status)

(c) functional capacity (degree of ability to walk, talk, see, hear, comprehend, dress, bathe, undertake personal care and household care.)

The demographic and functional capacity data is provided by a social worker-nurse team for the hospitalized applicant and by the Public Health, Victorian Order or St. Elizabeth Nurse for those applicants at home. The medical information is provided by the applicant's personal physician.

RECOMMENDATIONS

Recommendations are made on the basis of the information provided by the Health Care team with additional input as indicated and with an intimate knowledge of the available facilities and programs.

Recommendations include appropriate level of care, and/or programs of rehabilitation or recreation, and programs whereby the disabled person may be assisted toward a meaningful role in society.

REFERRAL PROCESS

Referrals are made by health professionals in the community or health care institutions and/or members of the community, and may be as simple as a telephone call asking for the process to be set in motion.

ADMINISTRATOR'S REPORT

Joyce Caygill

In 1984 we recorded an exceedingly busy year with a 3346 caseload; in 1985 we had a 3369 caseload, only a small increase in number yet we were much more busy than in 1984. We had occasion to review our work flow in an attempt to determine the causes of this increased activity. Our review shows us that the questions posed by callers seeking information are considerably more sophisticated and demanding than at the last review of this type (1982). Telephone queries are not only more numerous, each one also requires more staff time in terms of researching correct information for reply. Our findings caused us to reduce the amount of information coded for computer keypunch in order to put more staff time into answering queries. This was a decision made reluctantly because members of the general community have begun to rely on information which we have been able to supply as an adjunct to specific research. We have retained the coding procedures necessary for the maintenance of computerized waiting lists and related information. The areas we have discontinued coding are those which relate to physical function and diagnosis. We will continue to supply adequate data for monthly statistics and for the PASS system as well as those required by the Health Council for planning purposes.

Requests for educational sessions regarding the use of the PCS system have also increased in recent times. (see p. 8)

The 1984 report referred to the PCS evaluation grid which was approved by the Advisory Committee for the on-going evaluation of PCS efficiency and effectiveness. This report will follow the grid guidelines for measurement of achievement. (Copies of the grid are available upon request).

Our first major evaluation undertaking was the inter-rater reliability study which reviewed the recommendations made by the three PCS counsellors on 100 cases drawn by computer generated random selection from the 1982 caseload. The 1982 caseload was chosen in order to reduce the possibility of one of the counsellors recognizing the material despite all identifying information having been removed. The study was conducted by Dr. Michael Rachlis under the guidance of Dr. J. Lomas, of the Faculty of Health Sciences of McMaster University. Statistical analysis of the test results showed a gratifying level of agreement between 93% and 89%. We felt that this not only showed the high degree of agreement between the counsellors but also was a validation of the type of information we receive via the PCS Referral Form. (copies of the study paper available upon request) Our next study in this line should be a determination of the quality of the information provided to PCS via the form.

DATA BASE

Material for this Report was collected during the fiscal year April 1, 1984 and March 31, 1985.

Criteria for inclusion in the data base for this report were as follows:

- Parts A and B of the PCS referral form had been completed by the attending health professionals.

- the care needs identified by attending health professionals had been "matched" with care provided in various programs and a recommendation of the appropriate program had been made and recorded by PCS.

- either placement, death, refusal of placement, change of condition, or refusal of patient by a program had occurred to close the case.

Two thousand, two hundred and ninety one cases fulfilled these criteria.

REFERRALS

During the 1984-85 year we were involved with 3369 cases, of which 2625 were referred during the year. 710 persons were still unplaced at year end.

WAITING LISTS

Once again the waiting list size increased over the previous year with an average of 772 persons waiting for placement. Peak month was September with 861. This is despite the introduction in 1983 of the policy of removing the names of persons who were prepared to wait any length of time in order to be admitted to the facility of their preference, or who were not clearly ready to accept the decision to move; 237 persons were removed from the waiting list in this manner.

Experience has shown that 50% of those for whom a home for the aged is the appropriate placement will refuse a bed when one is offered. It is for reasons such as these that we remove the names of those who do not appear to have made a clear decision regarding acceptance of placement. Their cases can be reactivated at any time by means of one telephone call to PCS.

PLACEMENTS

The Henderson General Hospital opened a 38-bed chronic care (Type 3) facility in November of 1984. PCS was pleased to be of assistance in the choice of persons for admission.

A total of 206 persons were placed in chronic care facilities, 387 into nursing homes, with a further 38 persons requiring Type 2 care placed in the bed and special care sections of homes for aged. Forty-five persons accepted placement in the Type 1 sections of homes for the aged and two were admitted to couples quarters. (This number does not reflect those whom PCS may have referred to homes for the aged in the past, but who refused placement the first time it was offered. These persons may subsequently have accepted a placement without PCS being informed. PCS will be attempting to close this gap in 1985). One hundred and forty-nine persons were placed in lodging homes, which represents a considerable increase over previous years. (1983/84 = 107; 1982/83 = 86) (see Table III).

CLIENT SATISFACTION

Of the 1056 follow-up letters sent to clients on their families 4 to 6 weeks after placement, 648 replied, and 616 reported themselves satisfied. The 27 who were dissatisfied were contacted and either alternate arrangements were made, or attempts to ameliorate the problems were made by PCS staff. Unclear response: 5.

641 facilities/programs were satisfied with the clients we had referred, seven were not.

PCS counsellors were not satisfied that the final placement was the best for the client in 31 cases. Unfortunately, the ideal cannot always be realized either because the client refuses the suggested placement or the ideal accommodation is not available, or the waiting period is too lengthy.

COMMUNITY EDUCATION

During 1984-85 more than 300 visits were made by PCS staff to acute care hospitals, nursing homes and homes for the aged. All but three local facilities were visited at least once. In view of the large number of lodging homes in the Region of Hamilton-Wentworth we attempted to keep visits to new facilities only, however, our endeavour is to visit the over 80 such facilities at least once during the tenure of each owner/administrator of each home.

Orientation sessions for new staff were held for Public Health, Victorian Order and St. Elizabeth nurses, as well as for new coordinators and allied health professionals in the Home Care Programs. All new clinical social workers with involvement with

the elderly were contacted and the function of PCS described. Similarly, new nursing home administrators and directors of nurses were visited and assistance offered whenever necessary.

Upon request by faculty or students, nursing, occupational therapy, health care administration, and medical residents/interns have been provided with information sessions regarding both PCS and the long term care system. Students on placement in social service settings (social workers and aides) have been provided with similar sessions on the request of their supervisors.

All requests from church and senior citizens groups for a speaker or discussion leader have been honoured; PCS staff have appeared on local television programs aimed toward the elderly and their caregivers. Unfortunately, we have not been able to honour all requests for PCS staff to man booths at health fairs, conferences, etc. although all staff have served as resource persons or group leaders in seminars and health care conferences, as well as major long term care committees in the region.*

Monthly statistics have been forwarded to Executive and Medical Directors of hospitals in the Hamilton and Burlington areas as well as to the Directors of Social Work of these institutions. Statistics have also been provided to the PCS Advisory Committee and VON Board of Directors, Hamilton Wentworth District Health Council, Ministry of Health, Medical Officer of Health for Hamilton, Directors of the VON, Home Care and Public Health Nursing, together with a number of others both from Hamilton and other regions who have requested regular mailings.

A complete list of the committees, task forces, working parties, and media to which PCS staff have been either a resource or a member, together with a list of the reference materials available on-site to PCS staff may be sent on request.

TABLE I

AGE AT TIME OF REFERRAL

	1984-85	1983-84	1982-83	1981-82
5 - 9	0	0	2	2
10 - 14	0	0	1	2
15 - 19	6	1	2	13
20 - 24	7	6	12	5
25 - 29	12	7	7	3
30 - 34	11	10	13	4
35 - 39	8	11	8	5
40 - 44	16	9	8	11
45 - 49	23	9	22	17
50 - 54	31	40	42	43
55 - 59	55	68	67	54
60 - 64	107	105	104	112
65 - 69	175	159	160	148
70 - 74	279	242	292	266
75 - 79	410	399	412	354
80 - 84	519	417	461	363
85 - 89	393	454	392	317
90 - 94	172	195	184	152
95 - 99	52	53	50	44
100 - 104	9	9	7	16
Missing data:	6	7	0	7

TABLE II

LOCATION AT TIME OF REFERRAL

HAMILTON-WENTWORTH	1984-85	1983-84
Henderson Hospital	183	156
Hamilton General Hospital	155	143
St. Joseph's Hospital	210	152
*Chedoke Division	74	79
- geriatric assessment unit	48	66
*McMaster Division	112	91
St. Peter's Hospital	24	26
other Hamilton chronic	8	--
Hamilton Psychiatric Hospital	35	34
Community - private residence	1052	1023
- other	127	166
HALTON		
Hospitals	88	109
Community - private residence	83	58
- other	32	10
ONTARIO		
Hospitals	25	30
Community - private residence	22	25
- other	13	27
CANADA	0	0
missing data:	0	6
TOTAL	2291	2201

* Locations of Chedoke-McMaster Hospital

TABLE III

RECOMMENDATION & PLACEMENT

Number of places required		Number placed
Hamilton - chronic	441	187
Halton - chronic	44	8
other areas - chronic	15	9
*Family assistance - chronic	137	112
Life Support	9	1
Hamilton - nursing homes		348
Halton - nursing homes	795	26
other areas - nursing homes		13
Homes for aged - normal	444	45
- special	91	26
- bed	3	12
- couples	36	2
- vacation	4	0
- foster	1	0
Lodging Home	86	149
Home Care	15	54
other home supports	3	11
Day centres	135	36
Rehabilitation - Hamilton	2	3
- Halton	0	0
Geriatric assessment	0	0
Other	30	14
TOTAL	2291	1056

*Various names for respite/vacation/family relief beds.

EXPLANATION OF DIAGNOSTIC GROUPINGS

In view of the fact that it is usually the physical care needs that determine the type of care a patient requires from a program in long term care, the diagnoses have been grouped to provide a "picture" of the disease states of persons referred to PCS. Groups are as follows: code numbers relate to the coding system "International Classification of Diseases adapted for American use." (ICDA-8)

"Conditions related to cerebral dysfunction" - CVA, senile and pre-senile dementia, cerebral arteriosclerosis, cerebrovascular disease, senility, organic brain syndrome, affective psychoses, Alzheimer's disease. - (Codes: 290-299, 344, 432-438, 794).

"Conditions related to cardiac dysfunction" - rheumatic heart diseases, hypertensive heart disease, ischemic heart disease, arteriosclerotic heart disease, congestive heart failure, etc. (Codes: 391, 393-398, 402, 410-429).

"Neoplastic diseases" - (Codes: 140-199, 200-209).

"Conditions classed as arthritis" - osteoarthritis, rheumatoid arthritis, arthritis, rheumatism. (Codes 710-718).

"Hypertension" - (Code: 401).

"Diabetic conditions" - (Code: 250).

"Conditions related to respiratory dysfunction" - emphysema, asthma, bronchitis, chronic obstructive lung disease, pneumonia. (Codes: 480-493, 500).

"Hip fractures" - (Code: 820).

"Conditions related to central nervous system" - Parkinson's, epilepsy, cerebral paralysis, multiple sclerosis. (Codes: 340-349).

TABLE IV

DIAGNOSIS

Number of diagnoses recorded 5710

Average number of diagnoses per referral 2.5

N = 2291

Diagnosis	Absolute frequency	Percentage of 5710
1 Conditions related to cerebral dysfunction	1,525	26.7
2 Conditions related to cardiac dysfunction	702	12.3
3 Conditions classed as arthritis	370	6.5
4 Hypertension	360	6.3
5 Conditions related to CNS	296	5.2
6 Diabetic conditions	293	5.1
7 Conditions related to respiratory dysfunction	271	4.7
8 Neoplastic diseases	222	3.9
9 Hip fractures	153	2.7
	4,192	73.4

TABLE V

MEMORY AND AMBULATION

AMBULATION		MEMORY: NORMAL 1	FORGETFUL 2	PERIODS OF CONFUSION 3	MARKED CONFUSION 4	NO RECALL 5	ROW TOTAL
Fully	1	146	187	166	194	33	726
Ambulatory with cane	2	142	175	128	49	2	496
With wheelchair	3	91	98	58	43	10	300
Requires assistance	4	85	135	128	146	33	527
Immobile	5	24	16	48	61	63	212
Row Total		488	611	528	493	141	2261

Missing observations: 30

Shaded area represents persons for whom very little permanent placement is available.

TYPES OF CARE

(extract: Patient Care Classification by Types of Care, Ontario Ministry of Health publication #75-2222 8/75, pp3-4)

TYPE 1 (RESIDENTIAL CARE)

Care required by a person who is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

TYPE 2 (EXTENDED HEALTH CARE)

Care required by a person with a relatively stabilized (physical or mental) chronic disease or functional disability, who having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24 hour basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 3 (CHRONIC)

Care required by a person who is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psycho-social needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years.

TYPE 4 (SPECIAL REHABILITATIVE CARE)

Care required by a person with relatively stable disability such as congenital defect, post-traumatic deficits of the disabling sequelae of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of this TYPE OF CARE is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

TYPE 5 (ACUTE)

Care required by a person:

a) who presents a need for investigation, diagnosis or for definition of treatment requirements for a known, an unknown, or potentially serious condition; and/or

b) who is critically, acutely or seriously ill (regardless of diagnosis) and whose vital processes may be in a precarious or unstable state; and/or

c) who is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.

TERMINOLOGY IN COMMON USE IN ONTARIO

TYPE 1 CARE

Where provided

Homes for the Aged
Charitable institutions
Nursing homes
Foster homes
Group homes
Boarding homes
Homes for special care (residential care)
Children's institutions
Homes for unmarried mothers

Terminology

Domiciliary care
Ambulant care
Normal care
Residential care
"Intermediate care" in nursing homes
Community (social) support programs (mental)
- day care
- sheltered workshops
- supervised recreation

TYPE 2 CARE

Where provided

Homes for the Aged
Nursing homes
Homes for special care (nursing homes)
Children's institutions

Terminology

Extended health care
Extended care
Homes for special care programs

TYPE 3 CARE

Where provided

Chronic hospitals
Chronic care units in general hospitals
Nursing homes approved for chronic care
Geriatric units in psychiatric hospitals
Special facilities (schedule II) for mentally retarded with physical handicap
Children's institutions

Terminology

Chronic care
Care of the chronically ill
Chronic hospital care
Psycho-geriatric units (psychiatric hospital)

TYPE 4 CARE

Where provided

Regional rehabilitation centres

Terminology

Special rehabilitation care
Rehabilitation

TYPE 5 CARE

Where provided

Public hospitals
Private hospitals
(G.H.P.U.) psychiatric units of general hospitals
Provincial psychiatric hospitals
Private psychiatric hospitals
Community psychiatric hospitals
Children's mental health centres

Terminology

Acute care
Active treatment
Psychiatric care (short and medium term)

OPERATING EXPENSES

Year end - March 31/83	March 31/84	March 31/85
Salaries	132,668	148,138	155,692
Employee benefits	14,325	17,650	18,677
Space costs & services	14,085	15,492	16,560
Postage	2,350	2,301	2,188
Office supplies	4,081	6,854	8,331
Telephone	3,562	3,651	3,944
Travel	2,222	2,214	2,907
Data processing	3,360	3,360	3,704
Staff training	560	325	510
National Professional service dues (VON)	1,327	1,483	1,557
VON allocated costs	3,019	3,315	3,804
Advisory Committee expense	--	107	250
Other	180	354	286
Statistical info for Min. of Health (PASS) non-recurring expense	--	500	--
Audit (est.)	--	--	--
	181,739	205,744	218,696

NOTES

Data was accessed using the Statistical Package for the Social Sciences (SPSS) software package on the HP 3000 of McMaster University Computation Services Unit.

Codes include:

Diagnosis	ICDA-8 (International Classification of Diseases adapted for American use)
Location by facility	Ministry of Health Ministry Information System Division Data Development & Evaluation Branch Master Numbering System
Location by area	ibid, Residential Code
Physician	Ontario Health Insurance Plan Physician Index

ACKNOWLEDGEMENTS

We continue to enjoy the support and cooperation of the providers of health care in this area, and of McMaster University Computation Services Unit. We gratefully acknowledge their contribution to the continued operation of our service.